DRAFT Health Professionals Assistance Program (HPAP)
Program Service Committee Minutes

Date: March 11, 2020
Time: 12:30 pm – 3:30 pm CDT
Location: South Dakota Board of Nursing Conference Room
4305 S. Louise Ave
Sioux Falls, SD 57106

Present:

HPAP Program Service Committee (PSC) Members: Gloria Damgaard, Executive Director, South Dakota Board of Nursing (BON); Brittany Novotny, Executive Director, South Dakota State Board of Dentistry (BOD), and Kari Shanard-Koenders, Executive Director, South Dakota Board of Pharmacy (BOP).

Legal Counsel: via DDN: Steve Blair; Caroline Srtska, South Dakota Board of Medical and Osteopathic Examiners (BMOE); Shelly Munson, BON and BOD; Justin Williams, Department of Health; and via telephone, David McVey, BOP.

Others: Margaret Hansen, Executive Director, BMOE; Linda Young and Francie Miller, BON; Pat Beck, Court Reporter.

Minutes:

1. Meeting called to order at 12:30 PM.
2. The agenda was approved by consensus of PSC members.
3. The minutes of the HPAP PSC for December 12, 2019 and January 13, 2020 were approved for final posting by consensus of committee members.
4. A discussion was held related to the participation of the BMOE in HPAP. The main objective of the PSC was to identify a pathway whereby BMOE would allow physicians to voluntarily participate in the HPAP program with the current vendor Midwest Health Management Services, as requested by the SD State Medical Association and other physician stakeholders. Written information from the BMOE, along with a response by general counsel for the BON and BOD, is attached to these minutes. The PSC members identified opportunities for BMOE participation. M Hansen stated she would present the options to the BMOE and would provide a response to the PSC.
5. Pursuant to SDCL 1-25-2 (4), B Novotny motioned that the committee move into executive session for the purpose of reviewing vendor contracts. Seconded by K Shanard-Koenders.

G Damgaard, BON	Yes	B Novotny, BOD	Yes	K Shanard-Koenders, BOP	Yes
					Motion Carried

All legal counsel and the Executive Director of the BMOE were included in the session.

6. K Shanard-Koenders motioned that the committee move into open session, seconded by B Novotny.

G Damgaard, BON	Yes	B Novotny, BOD	Yes	K Shanard-Koenders, BOP	Yes
					Motion Carried

7. The meeting was adjourned at 3:30 PM by consensus of PSC members. A meeting will be scheduled following information from the BMOE to further discuss the return of the BMOE to the current HPAP.

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Attachment: Written information from the BMOE, along with a response by general counsel

The Board of Medicine will participate in the Health Providers Assistant Program (HPAP) by following what is authorized in SDCL 36-2A:

- ❖ As a starting point, it would appear then that the Board of Medicine agrees to once again participate in HPAP, which is great. Any health-related licensing board under Title 36 may join the jointly conducted HPAP. It appears from the below statements that we likely need to clarify what is "authorized" under SDCL 36-2A.

- HPAP is a state entity:
  - ❖ Using the term "state entity" has certain legal connotations that do not apply. More importantly, HPAP is defined by statute under SDCL 36-2A-1 as a "program" and not a separate "state entity."
  - ❖ HPAP is a "confidential program" designed to monitor and manage the treatment and continuing care of a regulated health professional who may be unable to practice with reasonable skill and safety if that professional's mental health issues or substance use disorder is not appropriately monitored and managed.
  - ❖ There is no dispute that the program is a state program however, as the state's health-related licensing boards jointly conduct the program to protect the public from impaired persons regulated by the boards. See SDCL 36-2A-2.
- with a state Boards and Commissions Program Service Committee (PSC) webpage for public notice and meeting agendas, materials, etc.
  - ❖ There is no dispute that the Participating Boards must establish a program service committee (PSC). However, no statutes or regulations require the PSC implement its own webpage for public notice, meeting agendas and materials. The PSC currently uses a state website for public notice and meeting agendas, which is sufficient under the statutes and regulations. I do not see where the statutes or regulations authorize the PSC to take this action of creating its own webpage. Nor does it make sense to burden the participating boards with creating and managing a website.
- with a state HPAP DotGov website independent of any one vendor for participant entry into the appropriate monitoring
  - ❖ Again, the statutes and regulations do not specifically authorize the PSC creating its own website and it would seem this service should be one that the contracted vendor provides.
    - BIT information regarding a DotGov website: "Since it would be a subdomain of an already-existing domain of ours, we can have it up and running in very little time at all. The thing to remember is that if it's a new website, it will start in a Development environment (hpapDEV.sd.gov) – once the code of the site passes a security scan, it will be set up in Test (hpapTEST.sd.gov), and again, once it passes a scan, it will then be allowed to go to Production. If it's simple code, then maybe one scan is all that will be needed, but the security scanning could make the Dev-to-Prod process take about a week or so, but likely less than that that."
  - ❖ The issue is not solely about creating a website, although this information is certainly helpful. If the PSC creates its own website, the PSC also has to update and manage the website. Because the monitoring and management duties are delegated to the contracted vendor to carry out based on the PSC's and Evaluation Committee's decisions, it seems appropriate that the contracted vendor create and manage any website needed to carry out the service requirements.
- whose participants meet the eligibility criteria as set forth in the statute 36-2A-7,
  - ❖ There is no dispute that the eligibility requirements for the program are specifically set forth in statute, which are copied and set forth below.
    - Eligibility for program. Admission to the health professionals assistance program is available to any person who is **impaired** and:
      (1) Holds licensure as a health care professional in this state;
      (2) Is eligible for and in the process of applying for licensure as a health care professional in this state; or
      (3) Is enrolled as a student in a program leading to licensure as a health care
    - "Impaired" is defined in SDCL 36-2A-1(2) as "the inability of a licensee to practice his or her health-related profession with reasonable skill and safety as a result of mental health issues or substance use related disorders[.]"

❖ What has been a matter of debate when it concerns the above quoted statutes is the definition of impairment. Notably absent from the statutory definition of "impaired" is the word diagnosis. There is no requirement that the licensee have a diagnosed mental health disorder or substance abuse disorder. Facts can establish impairment without a diagnosis. In other words, if an employer reports to a Board that the licensee tested positive for alcohol use while providing professional services, the Board does not first need the Licensee to be diagnosed as having a substance use related disorder for the licensee to become eligible for the program. The facts alone establish that the Licensee is impaired to the point the licensee is "eligible" for the program. If the Legislature meant to require a diagnosed disorder, the Legislature would have included that

in the definition. In addition, there is no reason for Participating Boards to impose restrictions or added burdens on themselves that are not required by statute or law.

- The statute refers to mental health "issues" and not disorders, so again the rules of statutory construction would support a finding of impairment without a diagnosed disorder.
- We may also consider the definition of "impairment" for eligibility in light of the grounds for denial into the program. SDCL § 36-2A-8 gives the grounds for denial into the program, which lists five reasons where the evaluation committee may deny admission: (1) the applicant is not eligible for licensure in SD; (2) the applicant diverted controlled substance for other than personal use; (3) the applicant creates too great a risk to the public; (4) the applicant has engaged in sexual misconduct; or (5) the applicant has been terminated by the health professional assistance program. The grounds for denial do not include lack of a clinical diagnosis of impairment.

- The PSC will comply with all applicable statutes and regulations, including state open meetings laws.
  - There is no dispute that the PSC must comply with all applicable statutes and regulations, including open meeting laws. Without any specificity, it's unclear what concerns exist that the PSC is not complying with all statutes and regulations. It should be noted however, when it comes to the open meetings laws, that the program is "confidential." Perhaps more clarity on the concerns will help determine if any change is needed to the process currently being followed.
- The PSC will run transparently, including recognition that all financial records of the PSC and its contracted vendors are a public record.
  - There is no dispute that the financial records of the PSC are a public record. Nor is there dispute that the amount the contracted vendor is paid for services is a matter of public record. However, no state agency may demand a contracted vendor provide its internal and likely proprietary financial records. For example, Woods Fuller is a contracted vendor of the State to provide legal services. Certainly the amount Woods Fuller is paid from any particular state agency is a matter of public record. But the State cannot demand that Woods Fuller make its profit and loss statements or any other financial records openly available as a public record. This demand is therefore not legally "authorized" under SDCL 36-2A or any other statute.
- The PSC will operate independently of Midwest Health Management Services (MWMS).
  - There is no dispute that the PSC is an independent committee for which the contracted vendor is not a member. There appears to be dispute regarding what duties and obligations each PSC, Evaluation Committee, and Program Personnel respectively perform. But certainly the committees and the contracted vendors are independent of each other. However, they also must work together in conjunction with each other. The program personnel, for example, need to report to the Evaluation Committee, certain facts and recommendations the contracted vendor has gathered, but the Evaluation Committee is the decision maker and directs the program personnel as to what action to take. The have independent roles, but they must work together to achieve the ultimate goal. We all agree the ultimate goal is to protect the public from impaired persons regulated by the boards.
- MWMS will be informed that they are not HPAP and cannot hold themselves out as HPAP.
  - HPAP is a program. Like any program, it consists of persons or agencies who operate the program. The HPAP program has the following arms to make it work: (1) Participating Boards; (2) Program Service Committee; (3) Evaluation Committee; and (4) Program Personnel. I have listed the arms in that order because the statutes give the Participating Boards authority to create a joint HPAP program by creating a PSC and having the PSC approve members of the Evaluation Committee and hire or contract with Program Personnel. The duties for each arm are set forth in statute.
  - The Program Personnel have the most contact with the Licensees in the program, and so, therefore, becomes a face to the program. The contracted vendor is an arm of the program by statute. And the contracted vendor needs to be transparent with Licensees that they indeed are operating as part of the program. When the contracted vendor is working with Licensees, the vendor must hold itself out as HPAP because it is only acting in that capacity as program personnel of HPAP. To operate otherwise would be misleading to the Licensee.
  - As stated above, there is no harm in discussing what duties fall under each arm of HPAP. I believe the flow chart tried to do that, but the duties under program personnel are not entirely accurate in the flow chart, so we should edit that portion and some other areas of the flow chart if the PSC feels such a document is necessary. I caution creating discoverable documents if they are unnecessary.
  - I would edit the program personnel duties on the flow chart to state as follows:
    - Conduct an evaluation of each Licensee applying for the program.
    - Advise the Licensee applying for the program of the program requirements, implications for noncompliance, and secure the Licensee's cooperation with the program.
  - It should also be noted that the PSC includes Board representatives who are likely paid through his or her respective Board. The Evaluation Committee, however, is a volunteer committee assignment. It is my understanding these members are not paid. The program personnel are paid through the contract with the PSC. To the extent possible, the duties for the Evaluation Committee should be accommodated by the PSC and program personnel.

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- The PSC recognizes that MWMS is a contracted vendor and that other vendors may be contracted to operate monitoring programs under HPAP.
  - ❖ There is no dispute that the PSC has legal authority under SDCL 36-2A-3 to hire program personnel for the joint health professionals assistance program. The PSC, as will be addressed below, will collectively vote on an annual basis what vendor to contract with to provide services. It is presumed that this occurs in conjunction with the PSC's annual evaluation of the program. The vendor selected by the PSC may be different than the vendor currently under contract. But there can only be one contracted vendor agreed upon by PSC vote. The statutes envision only a joint health professionals assistance program. If the program utilizes multiple vendors at the same time, the program is not joint at all. No Board can unilaterally contract with program personnel for HPAP. There is no legal authority for one Board to retain its own vendor. The statutes only provide this authority to the PSC, which is established by the participating boards. If the PSC does not retain the vendor, that vendor should not hold itself out as HPAP.
- All Chapter 36 health related boards that are participating in HPAP will have a representative on the PSC pursuant to 36-2A-3. All PSC members will have equal status and vote. Each PSC member shall have the opportunity to chair the PSC on a rotating schedule developed by the PSC. The chair of the PSC will have the responsibility to schedule, coordinate, and oversee the PSC meetings
  - ❖ There is no dispute that each Participating Board have a representative on the PSC pursuant to statute. And there is no dispute that each member have an equal status and vote. There is no legal authority to suggest otherwise. Creating a chair would potentially violate the equal status requirement, but if the chair's role is simply to schedule, coordinate and oversee PSC meetings, having a chair is not entirely objectionable.
  - ❖ However, scheduling and coordinating the PSC meetings is currently delegated to the contracted vendor as one of the services it must provide under the contract. This is a perk to avoid the PSC having to schedule and coordinate meetings, including preparing a proposed agenda. There is a benefit to the Participating Boards and PSC that the contracted vendor provides these services. Perhaps if we understand the Board of Medicine's rationale for this concern, we can better respond.
- The Board of Nursing and the Board of Medical and Osteopathic Examiners, with the approval of the other participating boards, will draft and promulgate rules for implementation of HPAP as required by SDCL 36-2A-14.
  - ❖ This is clearly set forth in statute already. The Board of Nursing and Board of Medical and Osteopathic Examiners have not yet promulgated any rules for implementing HPAP. The two Boards would have to jointly agree to draft Rules and then the other participating boards would have to all approve the proposed Rules before they could go through the process of promulgating the rules.
  - ❖ To this date, further regulation beyond the statutory authority has been unnecessary. Regulation should not be implemented if unnecessary. As of today, the only legal authority for HPAP is contained in SDCL 36-2A.
- Each PSC member, as a representative of their Board, has the authority to contract with a vendor(s) of their choosing.
  - ❖ As set forth above, this is prohibited by statute and counterintuitive to the existence of a program service committee and each board having a representative on the board with an equal vote. If each Board representative had the authority to contract with a vendor of his or her choosing, there would be no joint health professionals assistance program. The statutes under 36-2A do not "authorize" this request. The statutes under 36-2A only allow Title 36 health-related licensing boards to "jointly conduct a health professionals assistance program."
  - ❖ Each Board retains its authority to discipline violations of a board's practice act, but the statutes do not allow the Boards to each create a separate health professionals assistance program. As the statutes are written, the Board of Medicine cannot have its own health professional assistance program with its chosen vendor. Only the PSC may hire program personnel or contract with entities. SDCL 36-2A-1(4) specifically states that the PSC has sole authority to contract with or employ persons or entities to provide services for the program.
- The PSC will establish a fair pro rata share of program expenses to be borne by the participating board to pay only for its licensees that are participating in HPAP through their contracted vendors. One or two boards will not subsidize a vendor for the rest of the boards.
  - ❖ This request is also clearly set forth in statute, but there is certainly room for discussion as to how this logistically occurs. SDCL 36-2A-3(1) states that the PSC must establish the annual HPAP budget and the pro rata share of program expenses to be borne by each participating board.
  - ❖ It also appears in SDCL 36-2A-10 that a participant may be required to pay an initial participation fee set forth in Rule and the costs associated with the evaluations, treatment, and drug screens, but the PSC may want to discuss each Board requiring a Licensee to pay more than an initial participation fee to help offset costs. We need to discuss if Rule promulgation or statutory reform would be necessary to achieve this.
  - ❖ The existing HPAP program is effective and complies with statutory authority. The three arms of the program have operated well together to achieve the ultimate goal of protecting the public. There is no statutory authority for a similar program outside of this joint program that operates according to majority vote by the PSC. Any disputed items regarding the

operation of the program must be decided by the majority vote of the PSC. A Participating Board may elect not to participate in the joint HPAP, but there is no statutory authority allowing that non-participating board to create its own program.